ENCLOSURE

CALIFORNIA TITLE XXI PLAN
ADDITIONAL INFORMATION

Section 2. General Background and Description of State Approach to Child Health coverage

Section 2.3

1. Please clarify the interaction and coordination between MRMIB and the Department of Health Services in administering, monitoring, and evaluating the programs within this plan.

The Managed Risk Medical Insurance Board (MRMIB) and the Department of Health Services (DHS) have established a variety of mechanisms by which to coordinate in the administration, monitoring, and evaluation of the programs described in the plan. The mechanisms include:

- Both DHS and MRMIB report to the Secretary of the Health & Welfare Agency who can ensure that both agencies are operating under consistent policies and procedures;
- Kim Belshé, the Director of DHS, is a MRMIB Board Member. Thus, every issue before the Board is one which Ms. Belshé can comment on to other Board Members and vote on. Furthermore, the Health and Welfare Agency sits on MRMIB as an ex-officio member;
- DHS and MRMIB have created a Healthy Families Core Workgroup consisting of DHS' and MRMIB's senior management. The workgroup meets every other week to ensure coordination of the program. During these meetings, workgroup members provide status reports on the various projects being implemented and discuss implementation issues. This workgroup will continue to meet on a routine basis even after the Healthy Families program has opened;
- DHS staff have provided input to MRMIB staff on every version of the MRMIB Healthy Families regulations, as well as on the model contracts, negotiations and bids for the Healthy Families administrator and health plans. MRMIB staff have provided input to DHS staff on the application form common to both Healthy Families and Medi-Cal (Medicaid) for children, the outreach contract, and the outreach and media approach. MRMIB has also consulted with DHS staff on a range of issues such as Medi-Cal quality standards, Medi-Cal threshold language requirements, and the definition of traditional and safety net providers;
- DHS has created a new high-level management position (Associate Director) to facilitate coordination of the program within and between agencies. DHS has

filled this position with an individual who served as Deputy Director of MRMIB from 1991-1996; and

- DHS staff attend MRMIB's public meetings, including board meetings, and meetings with potential vendors to explain the model contracts.

2.a. The plan notes that enrollment in the AIM program is limited to women who are not on Medi-Cal or who do not have employer-sponsored coverage, "unless such coverage has such high deductibles that MRMIB views the coverage as tantamount to being uninsured." Please clarify whether this is applicable to children who would be covered through their mother's employer, since this policy would appear to allow substitution of coverage, which is not allowable under Title XXI.

California has historically served mothers and infants through its AIM program even if they have high deductible insurance coverage ($500 or more), because at the income of AIM mothers (200 - 300 percent FPL), out of pocket expenditures are so unaffordable that most mothers will be unable to use the insurance. The babies of these women may or may not have coverage once born. However, as Title XXI precludes states from serving children who have current insurance coverage, even this high deductible coverage, California will not bill the federal government under the Title XXI program to serve any infant who has access to other coverage. The AIM application asks not only whether a mother has coverage for her pregnancy, but whether that insurance will cover the infant that results from the pregnancy.

The AIM program has received a total of 30,146 successful applications to date, approximately 6 percent of whom qualified because of high deductible coverage. A total of 1,228 of these applicants indicated that their infants had access to other insurance coverage, 4 percent of the total application pool. California will track insured status of infants enrolled in AIM and will not claim federal financial participation for children whose mothers report the availability of health coverage for the infant. For estimation purposes, California has assumed that 4 percent of the children will continue to be ineligible for participation in Healthy Families. Thus, MRMIB will bill for 96 percent of the children under age one whose family income is between 200 percent and 250 percent of FPL and who are uninsured. Actual claims to the federal government will be based on the data collected on infant's insurance status from the AIM application.

2.b. Are children in the AIM program offered the same set of services as children in other insurance programs?

Children in the AIM program receive virtually the same set of health services as children in the Healthy Families program. These services are also quite similar to those of the Health Insurance Plan of California (HIPC.) All of these services were patterned on the Public Employee Retirement System (PERS) services.

Section 3. General Contents of the State Child Health Plan

Section 3.1

3. This plan includes a purchasing credit mechanism that provides families with funds to purchase dependent coverage through their employer for families who have reasonably priced employer-sponsored coverage for uninsured dependents but have been unable to finance the employee share. Further explanation of this mechanism is needed. Please address the following areas:

MRMIB has concluded that it is unable to implement the purchasing credit program until such time as state legislation can be enacted which corrects a drafting error in the authorizing statute. Specifically, language which limits the cost-sharing under the purchasing credit to a greater degree than the cost-sharing under the purchasing pool program needs to be revised so that cost sharing is the same. Consequently, we are temporarily postponing implementation of this portion of the state plan.

We continue to regard the purchasing credit as an important component of the Healthy Families program, as it enables families to purchase employer-based coverage and allows children to enroll in the same health plan as their parents.
The State believes it is in a family's best interests for a child to be in the same health plan as the child's parents and also views offering a purchasing credit as a crowd out mitigator. The State remains committed to making a purchasing credit available. The State intends to seek legislation to correct the technical problem described above and will then submit an amendment to the state plan to allow for implementation of the purchasing credit.

Section 4. Eligibility Standards and Methodology

Section 4.1.8

4. The plan proposes giving children whose family income increases beyond the Medicaid limit one month of continued eligibility under Medi-Cal and includes this in its proposed State Plan Amendment. Clarification is requested, since the continuous eligibility provision added by the BBA applies to a determination of eligibility and not ineligibility. Therefore, under the statute, continuous eligibility would only be available from the time of the initial determination for up to one year and, not as an add-on when someone is no longer eligible.

We understand that HCFA will not approve California's State Plan proposal to provide one month of continuous eligibility to children who have exceeded Medi-Cal's income level but whose income is below 200 percent FPL. This proposal which is specified in

California's state law was to provide families a transitional month of Medi-Cal coverage to provide time for them to apply for Healthy Families.

Based upon HCFA's direction that California's continuous eligibility proposal cannot be approved, we are withdrawing our original proposal. Based upon HCFA advice, we are proposing in its place that all children ages 1 through age 18 who are found by the County Welfare Office to have income greater than Medi-Cal standards (133 percent for children 1 to 6 and 100 percent for children 6 to 19) be given by the counties one month of expanded Medi-Cal eligibility at the enhanced 65 percent federal matching rate. This will provide these families with the time needed to enroll in Healthy Families without a break in the child's health coverage.

This proposal will require a change in state law which we intend to seek during the current legislative session. We anticipate that this feature will be available in September.

Section 4.3

5. The plan provides that certain agencies and providers will receive a $50 application assistance fee for assisting a family with their successful application. This $50 application assistance fee is currently being utilized by the AIM program. Clarification is requested as to the assumptions that were used in developing this fee.

In this section we will discuss the assumptions which led us to establish the amount of the application assistance fee. We describe the outreach proposal in Section 5.1. -- Question 12.a.

In California's state plan submission, we indicated that MRMIB would be using an application assistance fee of $50 which would be available to certain groups specified in MRMIB's regulations. These included child care centers, Parent-Teacher Associations (PTA's), and insurance agents and brokers, among others. The amount of $50 was obtained from the payment which MRMIB made for application assistance in two of its other programs (MRMIP -- the high risk pool -- and AIM). Originally, the fee had been set to reflect the cost for an agent or broker's assistance for application assistance and health plan selection. The fee assumed an agent/broker cost of approximately six percent of premiums, an amount which represented the low end of the agent reimbursement spectrum in the commercial market.

Since submission of the plan, MRMIB and DHS have concluded that it would be inconsistent with federal requirements to allow any of the application assistance fee-eligible entities to assist with health plan selection. As a sizeable portion of the $50 fee had included reimbursement for working with the applicant on health plan selection, DHS and MRMIB decided to reduce the fee.

Staff then assessed the cost of providing application assistance by a community-based organization (CBO.) Assuming that the assistance would be provided by a paraprofessional staff person for 300 days per year, and would include four client interviews a day/site, an hour of travel, and two and a half hours/day for phone calls, administrative work, and technical assistance to other applicants, the cost/call would be $25.13. These costs are based on actual costs for the WIC program and do not include any time spent on assisting with health plan selection.

Thus, adjusting the application assistance fee to reflect the fact that assisters will not help applicants with health plan selection, MRMIB and DHS have set the fee to $25.

6. Managed care organizations will be allowed to compete for the administrative vendor contract. The administrative vendor will conduct eligibility determinations, premium collection, payment of the assistance fee and other enrollment functions. How does the State plan on avoiding a potential conflict of interest in awarding this contract?

The State does not want to arbitrarily limit the types of entities that may compete to provide administrative services to the Healthy Families Program. MRMIB historically has allowed health plans to bid on the administrative vendor contract for all three of its existing programs and has selected both health plans and a third party administrator as vendors. Today, all three programs are administered by health plans. In one instance the administrative vendor also participates as a health care provider. Some competing health plans initially expressed concerns about potential conflict of interest. However, MRMIB has insisted that health plans seeking to become an administrative vendor set up "fire walls" separating health plan operations from administrative vendor operations. In its three operations, MRMIB has never had a complaint from a health plan or a subscriber/applicant asserting that the administrative vendor has acted improperly with regard to presentation of a potential or continuing subscriber's health plan choices.

MRMIB will be awarding the administrative vendor contract in February. Consistent with its experience to date, the State also allowed health plans to bid for the administrative contract for the Healthy Families Program. In the procurement process, three categories of potential vendors have applied -- health plans, electronic data processing firms, and third party administrators. MRMIB has received eight proposals, three of which are from health plans. In the November 1997 proposal solicitation documents, health plans seeking to be selected as the administrative vendor were asked to describe the steps they would take to separate their health plans and administrative vendor operations. MRMIB anticipates that each of those health plans vying to become the administrative vendor will also be bidding to become Healthy Families health plans.

The State has researched federal law to determine if a proposed administrative vendor who is also a health care plan would violate any federal provisions applicable to Title XXI of the Social Security Act. The State has determined that only one federal law, 42 USC 1396a (4)(C), as amended by the Balanced Budget Act of 1997, applies to the Healthy Families Program pursuant to Section 2107(e) of Title XXI. Section 1396a (4)(C) requires that certain officers, employees, and independent contractors be prohibited from engaging in any activity prohibited under Sections 207 and 208 of Title 18 of the United States Code. The State intends to comply with these sections and does not think that having a health care plan act as the administrative vendor would violate 42 USC 1396a (4) (C).

Although Title XXI is subject to 42 USC 1320a-7b(b), the State has determined that the section does not apply to the Healthy Families Program because the duties of the administrative vendor would not be activities covered under the section. The vendor will not arrange for health care services or auto assign applicants to any given plan. The applicant makes the choice of health plans and the vendor is prohibited from recommending or steering an applicant to any plan.

In addition, 42 USC 1396v, as amended by the Balanced Budget Act of 1997, which prohibits a health plan from being an enrollment broker for a Medicaid managed care organization, is not applicable to Title XXI.

In the last few weeks MRMIB has received several letters expressing concern about the administrative vendor being allowed to participate as a health plan in the program. The State's view is that whichever type of entity provides the best combination of excellent customer service and cost effectiveness is the one that should be chosen. If that entity is a health plan, the state is confident that firewalls (as described below) and monitoring by MRMIB will remove any potential for conflict of interest.

Any action to disallow the use of a health plan as the administrative vendor would impact the procurement process and may cause significant delays in the implementation of California's Healthy Families Program.

The firewall requirements established for the administrative vendor (found on pgs. 14, 15, 24, and 25 of the Administrative Vendor Model Contract) include:

- Conducting administrative functions of the program in a separate physical area from other business activities;
- Creating an administratively separate organizational structure for staff responsible for the program;
- Blocking access to program databases and files by other parts of the Contractor's organization unless expressly authorized by the State;

- Not using prospecting lists or any other information obtained for the program for use in the Contractor's other business activities;
- Maintaining an open door policy with participating plans, allowing those participating plans to observe its administrative processes, and granting those plans the ability to influence how they are represented by the program's representatives;
- Establishing and maintaining stringent security measures on all hardware, software and program files to ensure the confidentiality and integrity of applicant and subscriber files, and to restrict access to confidential materials;
- Requiring the vendor to develop a process to assure that participating plans' concerns regarding eligibility and enrollment issues are resolved in a timely manner;
- Requiring the administrative vendor to develop and implement a process whereby benefit or participating plan customer service related concerns are traced and transmitted to the appropriate plan for resolution. A summary of these data must be provided monthly to the State;
- Not allowing the administrative vendor selected (health plan or not) to use its company name on program materials. Rather, all materials will refer to the Healthy Families program;
- Requiring state approval of all published materials, including materials which describe health plans in the application brochure;
- Using scripts prepared by each plan to answer phone inquiries about coverage provided by the plan; and
- Requiring any health, dental or vision plan seeking to become the administrative vendor to include in their proposal a statement of how it will assure the separation of plan operations from administrative vendor operations.

Additionally, health plans seeking to become the administrative vendor have suggested additional firewalls in their proposals. MRMIB intends to incorporate these additional firewalls in their contract with the administrative vendor, if it selects a health plan. These include:

- Involving MRMIB in the development of performance based incentive programs for the managerial staff to ensure that the incentives are disassociated from any potential conflicts of interest;
- Providing on-site work space for a MRMIB employee located within the physical unit where HFP administrative activities will take place. The employee will have unrestricted access to HFP administrative facilities and operations, be invited to all internal meetings regarding HFP administration, be able to monitor telephone calls between administrative staff and applicants, and be able to monitor all data systems functions;
- Recording all telephone calls. Tapes of the telephone calls will be made available to MRMIB, health plans, and external auditors, as required;

- Creating links to participating plan websites on the HFP website; and
- Conducting regularly scheduled meetings with participating plans to discuss issues regarding the administrative function. Participating plans will help create the agenda for these meetings. MRMIB will approve any actions proposed at the meetings.

If MRMIB selects a health plan as its administrative vendor, it will use the following strategies to monitor for violations of conflict of interest, in addition to the strategies noted above:

- MRMIB staff periodically will make calls to the vendor posing as potential applicants to see if vendor personnel make any effort to induce them to choose their company's health plan;
- MRMIB will investigate any complaints by competing health plans or applicants regarding steerage of applicants to one plan over another; and
- MRMIB will track enrollments by health plan and conduct eligibility audits on a periodic basis.

7. How does the State propose to make sure that if a Medicaid determination for eligibility is needed that the Medicaid State Agency makes the final determination?

The Healthy Families' administrative vendor will not have the ability to or the responsibility for determining Medicaid eligibility. Medi-Cal application processing and determination will be made by the county welfare office. The application contained in the joint application package contains a worksheet designed to assist families who appear to be eligible for Medi-Cal in mailing their application directly to the county welfare offices. Families who appear to be Healthy Families eligible will mail their applications to the MRMIB administrative vendor who will determine Healthy Families eligibility or ineligibility. If the vendor determines that the child meets Medi-Cal eligibility criteria, the vendor will deny the Healthy Families application, notify the family, return the premiums to the family and, with the family's consent, forward the application to the county welfare office for processing.

Alternatively, in the event that the family incorrectly applies to Medi-Cal, the county welfare offices will, with the family's consent, mail their application to the MRMIB administrative vendor. Once a family has mailed in an application, the "system" will take on the responsibility to see that the application is processed by the appropriate program, but neither will make the other's determination of eligibility.

Section 4.4.1

8. Clarification of the Medicaid eligibility screening process is requested. How will the State determine the specific income disregards that will be used in determining

eligibility under the Healthy Families program? What assurances can the State provide that children determined eligible for Healthy Families are not eligible for Title XIX due to differences in income disregards or a different budget period for evaluating income?

DHS and MRMIB are developing a joint application for children's Medi-Cal and Healthy Families, and will collect income information and income disregards using the same data fields and budget period (one month). DHS and MRMIB staff have reviewed the extensive list of income disregards that exist for the Medi-Cal program to determine those that are either frequently used in Medi-Cal for children. Disregards that have extensive usage in Medi-Cal, such as work expenses, child care, child support payments, and income of a child while in school, have been established as income disregards for Healthy Families. Due to the complication that adding all of the Medicaid income disregards would create for Healthy Families eligibility determination and the very small impact the addition of infrequently used Medicaid income disregards would have on who was determined eligible for Healthy Families, these disregards were not adopted for Healthy Families. Instead, the application guide will advise families whose income is slightly above the Medi-Cal maximum and who have unique circumstances that they may still qualify for Medi-Cal and that they should apply to Medi-Cal first. Further, as part of the State's outreach process, we are providing reimbursement to with community-based organizations (CBO's) who assist families in completing applications for both programs. These CBO's will be instructed on how to assist families with income disregards.

Families that apply for Healthy Families will have their application screened for income and income disregards. Those families whose income, after deducting the disregards, based upon family size, qualify for Medi-Cal will have their Healthy Families application denied and forwarded (if they agree) to the county for Medi-Cal eligibility processing.

To add numerous additional income disregards would add extensive complication to the application form with no real value. We believe our approach protects families with rare deductions from applying for Healthy Families if they are Medi-Cal eligible. Further, we believe our approach far exceeds that required by federal law, as well as the approaches adopted by other states.

The eligibility changes described above are reflected in the final version of the Healthy Families Program regulations which the MRMIB adopted on January 29, 1998, under the definition of gross income (See Attachment A).

9. In the Medi-Cal program, a resource disregard is being implemented. How will the State assure that the enhanced match will only be made available for children who are newly eligible because of the elimination of the resource test?

In accordance with the provisions of the Balanced Budget Act, California has expanded Medicaid eligibility for federally targeted children who heretofore were not eligible for Medi-Cal because their parents had excess assets. Implementation of the resource disregard for Medi-Cal is a key component to California's effort to outreach to and enroll the estimated 400,000 children who meet Medi-Cal eligibility standards but who are not enrolled. The resource disregard removes several pages from the Medi-Cal application for children and allows use of a mail-in application as well as a joint Medi-Cal and Healthy Families application. Without the resource disregard, the goal of expanding Medi-Cal coverage for qualified children set by the State, Congress, and the President could not effectively be achieved.

Accomplishing the goal of simplifying the Medi-Cal application form, in large part by removing resource information, has placed California in a "Catch-22" situation. To reach and cover more children and make Medi-Cal and Healthy Families work together, we have eliminated asset/resource information from the application. However, in removing this information we lose the identity of who those children are, and thus raise HCFA's concern. We urge HCFA to accept an interpretation that does not penalize California for taking action needed to cover more children who are at the lowest income levels. Our approach is consistent with the goals of Title XXI.

California's preferred approach to ensure proper claiming for the 65 percent enhanced match is to sample on a periodic basis, through our quality control process, families in the percentage poverty programs. This allows the State to determine the percentage of those families in these programs that qualify due to the resource disregard and can be claimed at 65 percent. We are prepared to work with HCFA on sample size and how often the sample would be done.

If HCFA is unable to accept a sampling methodology, we propose to claim 65 percent FFP for children made newly Medi-Cal eligible due to the resource disregard by adding two questions on resources to the application form. This approach is less desirable because additional questions on the application form increase its length, potentially creating barriers to enrollment. These two questions would ensure that the enhanced match will be made available only for children who are newly eligible because of the elimination of the resource test. California will include (on the Medi-Cal-only form of the joint application) a question asking applicants whether they own more than one car for personal use and a question asking whether their bank accounts fall above an established level. If the applicant reports assets in either category above a level corresponding to prior California Medicaid law, the State will assume that the applicant has expanded eligibility due to the income disregard and eligibility for 65 percent FFP.

As we are nearing our deadline for finalizing the application form to meet HCFA's requirements, the questions have been added. However, if HCFA approves a sampling methodology, we would remove these questions in future revisions to the application.

Section 4.4.3

10. The Plan indicates children will be ineligible if they have been insured within the prior three months. Although the plan notes that the State's enabling statute makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the program, how will the State avoid employees dropping their current coverage to enroll their children in CHIP? The State should also be aware that the Department of Health and Human Services is considering establishing a policy in regard to crowd out provisions and that the State would be required to comply should such policy be adopted.

10.a. We share HCFA's concern, also expressed in Title XXI, that steps be taken to minimize the potential for employers or individual employees to drop their current dependent coverage to take advantage of subsidized coverage. Such "crowd out" seems to be a potential consequence of making available subsidized coverage for children. However, given that several researchers have found that crowd out is not a serious concern when subsidized programs are limited to children, the state is not sure how big a danger crowd out might actually be.[1]

Nevertheless, we believe that the measures we have adopted in our authorizing statute are among the best approaches to prevent crowd out. Features to avoid crowd-out include:

- Creation of a "firewall" which prevents children from participating in the program if they have had employer-sponsored coverage within three months of application. MRMIB is authorized to increase the firewall time period from three to six months if it finds that the program is covering substantial numbers of children who were previously covered under employer-sponsored plans;
- Establishing copayments for non-preventive services;
- Prohibiting insurance agents and insurers from referring children to the program when they already had coverage under an employer-sponsored plan. Violation of the prohibitions would constitute unfair competition under the Business and Professions Code;

[1] See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, "Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience" (October 1997); Children's Defense Fund, "Fears That Employers Coverage Will Fall If Uninsured Children Are Helped Are Exaggerated" (November 1997); and Center for Health System Change *Issue Brief No. 3,* "Medicaid Eligibility Policy and the Crowding-Out Effect" (October 1996).

- Making it an unfair labor practice for an employer to refer employees to the program for children's coverage where the employer provides such coverage or for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the program; and
- Directing MRMIB to develop participation standards that minimize crowd out.

MRMIB will monitor applications to determine whether employers or employees have dropped coverage to participate in the program. Specific monitoring strategies that the Board will consider include the use of a third party evaluator, and subscriber or employer surveys to measure the extent to which crowd-out has occurred.

The state is aware that HCFA is developing a crowd out policy and would be interested in commenting on that policy before it is adopted. HCFA should be aware that California, like many states, has adopted state legislation based upon the federal law giving states broad authority. We ask that HCFA keep in mind the impact of any such policy on state law and the state's commitment to make Healthy Families' coverage to uninsured children by July 1, 1998. Furthermore, California notes that the federal statute authorizing the "State Children's Health Insurance Program" does not provide the U.S. Department of Health and Human Services the authority to require states to meet national crowd out standards as a condition of eligibility for federal funds. While California is committed to remaining a leader in the development and use of strategies to avoid crowd out, each state should be allowed to set its own crowd out strategies without interference from Washington.

10.b. We would also like to raise with HCFA an issue that the State believes could exacerbate crowd out. The State believes that uninsured children have a high, unmet need for dental services. For example, the most frequent medical need identified in health screens done in our Child Health and Disability Prevention program (EPSDT for uninsured children with incomes above Medi-Cal levels) is dental services.

The State believes that an additional important crowd out mitigation measure would be to allow children with health coverage -- but no dental or vision coverage -- to buy dental and vision coverage through the program. We are aware that children with health coverage are ineligible for the Title XXI funded programs. However, permitting families to remain in their employer-based coverage while accessing the HFP dental and vision benefits could be an important mechanism for discouraging parents of children with little or no vision or dental coverage from dropping the employer-sponsored health care in order to access such benefits through Healthy Families. Provision of such coverage would be at a fraction of the cost per child of the full Healthy Families Program benefit package. We want to raise this issue to you as you consider any possible legislative changes to Title XXI or possible Title XXI waivers.

11. An exception to the three-month limitation prohibiting coverage of children who have had employer-sponsored coverage is the discontinuation of health benefits to all employees by the applicant's employer. Please discuss how this exception is consistent with the State's efforts to discourage crowd out.

As you are aware, there are several exceptions to the application of the three-month rule provided for in statute. These exceptions recognize circumstances in which an employee has lost coverage through no fault of their own. They are detailed on page 29 of the State Plan. The exception for which you seek additional information is one in which an employer discontinues health benefits to all employees.

California does not support a mandate for employers to provide coverage for employees and their dependents. However, many employers may chose to provide employees with health benefits to make their business an attractive place to work. To cancel employee coverage -- thereby making all employees (and the employers themselves) uninsured -- to force the employees to pursue coverage for their children in Healthy Families would create labor problems for the employer, cause the employer to be in violation of several provisions of the Labor Code (which angry employees would be likely to report), and reduce the employer's attractiveness to new employees. It seems most unlikely that an employer would take on all these problems in an attempt to avoid coverage of children for a portion of his or her employees. This view seems to be supported by the research (cited in 10.a.) that has found minimal crowd out problems in children-only subsidized programs for families at or below 200 percent FPL.

Thus, children left uninsured because their parents' coverage had been terminated due to financing decisions made by their employer represent truly uninsured children who should have access to Healthy Families coverage. Since employers who drop children's coverage because of Healthy Families are held accountable under state labor law, it is not necessary or prudent to punish these children for an employer's business decisions.

Section 5. Outreach & Coordination

Section 5.1

12.a. In this section, we will describe the state's outreach plan as it has evolved since the state submitted the state plan in November.

During Board hearings, MRMIB heard concerns from a number of groups that the dual outreach approach, as described in the initial State Plan, could result in uncoordinated and duplicative outreach efforts. The Board directed staff of MRMIB and DHS to work together to develop a consolidated effort. The staff developed a revised consolidated outreach effort which is described below. The media portion of the contract will operate as described in the State Plan.

To complement the media campaign, the State will fund an extensive grass roots outreach effort using pay for performance reimbursement of local individuals and entities. The grass roots effort is based on a "people helping people" model in which a broad range of individuals and entities are trained to assist families with the joint Medi-Cal/Healthy Families application.

Funding for application assistance fees paid to CBO's will come from DHS. Funding of fees paid to health care providers and insurance agents will come from MRMIB. All funds will be administered through Runyon, Saltzman & Einhorn (RS&E). Through RS&E, training sessions and continuing education courses will be offered to representatives of local entities. These community organizations include local health departments, licensed day care operators, schools, faith based organizations, community clinics, and insurance agents. The training will provide participants with skills in assisting families to complete the joint application.

Upon successful completion of the training, the representatives of the organizations will be authorized to conduct training sessions with other persons in their organization. The organization's trainer will have to certify which employees have completed the training and attest to understanding program rules and regulations. Agent/brokers can be trained via a course for which continued education units (CEU's) are available. RS&E will develop the curriculum for the training as well as conducting the training sessions.

Once a person is certified as trained, he or she is eligible to assist applicants (for both Medi-Cal and Healthy Families) and bill for the assistance fee. The fee will only be paid after verification of enrollment. The fee will be paid no more often than once for any child/family in any given twelve month period and will also be available for case assistance provided during the annual requalification.

When a CBO, provider, or agent's bills for the $25, the person providing the assistance will sign a certification that they did not assist the family in health plan selection nor violate any of the State's other requirements. In the Medi-Cal program, conflict of interest is not problematic because choice of health plan is an entirely separate process that occurs after eligibility has been determined by the county. The joint application form being developed for Medi-Cal and Healthy Families contains an item for designation of health plan for the Healthy Families Program portion of the application exclusively. Further, since the state will be requiring the assisters to certify that they understand program rules and regulations, the state will be able to prosecute any assister that does make plan recommendations.

DHS will establish an outreach working group to advise RS&E, the Department, and MRMIB on the efficacy of its outreach and education strategy. Healthy Families will monitor program experience to ensure compliance with program rules, particularly those

related to conflict of interest, by having the administrator ask the applicant at the time of the welcome call (10 days after enrollment) whether anyone attempted to refer the applicant to a given health plan. In addition, DHS and MRMIB will assess the experience of this approach over time to determine if it is meeting its goals of facilitating the enrollment of eligible families into Healthy Families and Medi-Cal. Finally, we would note that a Medi-Cal specific outreach and education effort, focused on children who are uninsured but Medi-Cal eligible, will be conducted. This campaign will operate under the same principles and strategies as the Healthy Families Program campaign.

12.b. What procedures will the State use in determining what language will be designated as threshold languages? Will language thresholds be applied statewide or county wide? As Title VI of the Civil Rights Act of 1964 requires the state to provide all patients of limited English proficiency an equal opportunity to benefit from provided services, how will the State ensure that persons of limited English proficiency who are not fluent in one of the ten designated languages will receive understandable materials so that they may equally benefit from the services being provided?

DHS and MRMIB are committed to meeting the requirements of Title VI of the Civil Rights Act of 1964 by ensuring that non-English speaking persons are included in outreach, media and enrollment activities. Below we describe how DHS will address outreach to non-English speaking populations and how MRMIB will address access to enrollment materials for these populations.

DHS Outreach & Media Contractor

In implementing the Outreach and Media contracts for both Medi-Cal and Healthy Families, DHS, through its outreach and media contractor, RS&E, will:

- Translate the joint Medi-Cal/Healthy Families application pamphlet into ten threshold languages: English, Spanish, Cantonese, Russian, Farsi, Cambodian, Laotian, Hmong, Vietnamese, and Armenian. Counties with high populations in other languages will do further form translations as they currently do for the existing Medi-Cal form;
- Maintain a toll-free outreach number with operators who speak English and Spanish and who have access to the AT&T translation service for all other languages;
- Place outdoor advertising in the threshold languages wherever at least 1,000 Medi-Cal recipients in a given zip code speak one of the languages.
- Develop outreach print materials in the ten threshold languages, including material to be published in newspapers and periodicals published in the ten threshold languages;

- Conduct radio and TV spots in English and Spanish; and
- Recruit a diverse cultural, linguistic and geographic mix of CBO's to assist applicants, focusing particularly on those with an existing relationship with subpopulations of the target group. The CBO's will help ensure that the target populations can access program information and assistance.

Healthy Families Administrative Vendor

MRMIB is aware that its program needs to serve the linguistic and cultural needs of California's diverse population. In fact, MRMIB anticipates that as many as 60 percent of children who will be served by Healthy Families will be Latino. The Model Contract for the administrative vendor requires the vendor to:

- Describe how the organization will approach communicating effectively with a linguistically diverse population;
- Print Healthy Families specific information included in the application packet (the joint application and Healthy Families brochure) in the 10 threshold languages;
- Translate all Healthy Families Program materials into ten Medi-Cal threshold languages in year one. MRMIB will reevaluate this strategy during the program's second year to assess if Medi-Cal's threshold languages are appropriate for Healthy Families;
    - Maximize the availability of non-English written materials, per the requirements of Section 7290 of the Government Code. This statute requires that a state agency make non-English languages available to the extent that 5 percent or more of the population being served speaks a particular language. The Board's review of the primary languages spoken by the 113,117 statewide share-of-cost Medi-Cal enrollees between the ages of 1-18 during the sample month of January, 1998, shows the following: English, 52,062; Spanish, 55,585, Vietnamese, 1567; Cantonese, 1,225; Tagalog, 423; Korean and Russian, 217 each; Hmong and Laotian, 128. Based on this review, the Board's administrator would publish materials in English and Spanish. The Board has decided to exceed the requirements of Government Code Section 7290, at least for the first year;
    - Assure that all translated materials are an accurate and culturally sensitive translation of the English version. The vendor must have two independent readers verify the accuracy of each translation. The contract specifies that the vendor must have application package and other materials available in all the threshold languages by June 1, 1998 or be subject to liquidated damages;
    - Have trained English and Spanish speaking staff on site between 8 AM and 8 PM weekdays and have the capability to provide telephone services

via a translation service for all other languages in the threshold languages identified above; and

- Establish a Network Information Service for subscribers which, among other data, will list languages spoken at each provider's office.

Section 7. Quality and Appropriateness of Care

13. How will MRMIB identify specific quality assurance measures to include in its contracts that are appropriate for the Healthy Families population? Please clarify how quality standards for AIM and the purchasing credit program will be implemented and monitored, since this is not addressed in the plan. Clarification is also requested regarding the quality assurance measures to be used for those services, such as mental health services (pg. 44) that are not under MRMIB's purview.

Healthy Families Quality Assurance Measures

Below are the quality assurance measures for the Healthy Families purchasing pool. California will address quality assurances for the purchasing credit when it submits a State Plan Amendment.

Measuring Clinical Quality: The model health plan contract requires contractors to provide the state with audited clinical measures consisting of the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) 3.0 Performance Measures as well as any age relevant HEDIS measures which are included in versions of HEDIS numbered higher than 3.0. Plans must also report the number of subscribers who received a health assessment visit within 120 days or four consecutive months after their effective date of coverage. These data must be measured or audited by an independent third party and reported annually. MRMIB may use the data to provide information to subscribers in its annual open enrollment or program application materials.

Standards Designed to Improve the Quality of Care: Health plans are required to assure that its providers will use the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to recommendations for preventive pediatric health care. Annually, the plan must inform the caretakers of its enrollees of the AAP's recommended schedule of preventive care visits. The notice must be in English, Spanish and any other language which is spoken in more than 5 percent of the plan's enrollees' households.

Quality Management Processes: The contractor must assure the State that its Quality Management processes have been reviewed and found to be

satisfactory by either the National Committee on Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, or the State of California's Medi-Cal Managed Care program. The contractor must also maintain a system of accountability for quality improvement activities which includes the participation of the contractor's governing body, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of quality improvement development and performance.

Risk Assessment and Adjustment Process: MRMIB will implement a risk assessment and adjustment (RARA) process for Healthy Families similar to that which MRMIB uses in the HIPC. MRMIB believes that risk adjustment is critical to providing quality care. RARA provides the necessary balance to the aggressive price negotiations undertaken in a purchasing pool. Through use of risk adjusted premiums, plans that provide quality services in an efficient manner accrue financial benefits. MRMIB intends to implement RARA in the third year of program operations.

Ongoing Efforts to Improve Quality Measures and Accountability: MRMIB will establish a Children's and Adolescent's Clinical Quality Improvement Work Group. The purpose of the group is to expand the number of reportable clinical quality measures and develop an approach to increasing health plans' accountability for clinical quality improvements. The starting point for the work group's activities will be the December 4, 1997 report "A Clinical Quality Accountability Framework: California's Healthy Families Program" (See Attachment B), particularly the section on standardized patient satisfaction monitoring and reporting. The workgroup will meet at least quarterly and will develop recommendations for improvements to the program's quality improvement strategy by December of 1999. These recommendations would be incorporated in contracts for the contracting period July 1, 2000 through June 30, 2002. The work group may also make interim recommendations for the contract year July 1, 1999 through June 30, 2000. Health plan contractors must participate in the workgroup.

AIM Quality Assurance Measures

The AIM program relies on the quality assurance requirements of the Knox-Keene Act which regulates health plans. These requirements are detailed on pg. 20 of the state plan and include requirements governing accessibility of health services, consumer protection and quality assurance. Quality assurance requirements specifically require that plans have quality assurance programs, and that providers establish a program to review the quality of care being

provided and identify, evaluate and remedy problems related to access, continuity of care, utilization and monitoring of plan providers.

Quality Assurance Measures for Programs Not Under MRMIB's Purview

County Mental Health Programs: County mental health programs are overseen by the state Department of Mental Health. The requirements for quality assurance will be those used for Medi-Cal beneficiaries under the Short Doyle Medi-Cal program. In addition, DMH is developing a performance outcome system for children with serious emotional disturbance.

Quality Management Systems for Short-Doyle Medi-Cal: The following is a description of the quality management system which is used for specialty mental health services under the Short-Doyle Medi-Cal program. The Department of Mental Health requires each local county mental health department to have a Quality Management Program. The components of this program are described in the paragraphs below. The Department conducts a review of access and quality of care at least once every 12 months and issues reports to each county detailing findings, recommendations and corrective action as appropriate. The Department performs its monitoring function by inspecting or auditing facilities, management systems and procedures, books, records (including the Quality Management plan), grievance/complaint logs and data.

Quality Management Definition: Quality Management as established in the Short-Doyle Mental Health system is an integrative process that links knowledge, structure and processes together to assess and improve quality. Quality Management processes are those activities that the county mental health department undertakes to improve the quality of clinical care, clinical services, and consumer services. Each county's quality management program includes a written quality management plan, a quality improvement committee with designated health care professionals with substantive management and clinical experience and a specified active role for practitioners, providers, consumers and family members.

Quality Management Plan: At the local level, the quality management program coordinates performance monitoring activities including client and system outcomes, utilization management, credentialing and monitoring of providers, assessment of beneficiary and provider satisfaction, clinical records review and resolution of beneficiary grievance and fair hearing and provider appeals. The methodology for these functions is detailed in the county's local Quality Management Plan.

Each local mental health department must set standards and establish systems to monitor the following:

- Timeliness of routine mental health appointments;
- Timeliness of services for urgent conditions;
- Access to after hours care; and
- Responsiveness of the county's toll free 24 hour telephone.

Additionally, at least once each year counties survey for beneficiary and family satisfaction and review the numbers and types of beneficiary grievances. Fair hearings and requests to change persons providing services are evaluated at least annually.

The local mental health department also identifies meaningful clinical issues relevant to its beneficiaries for assessment and evaluation. These issues always include a review of the safety and effectiveness of medication practices and may include other important clinical issues such as procedures and interventions used to respond when an individual is potentially suicidal.

Quality Improvement Committee: Each county, through their Quality Improvement Committee, also establishes quantitative measures to assess performance. Some of these indicators are monitored for the entire population and could include length of stay in inpatient facilities, recidivism, and total number of acute psychiatric bed days. Examples of measures which are specific to children include numbers of children and youth in group home placements and numbers of youth and children involved in the juvenile justice system.

Documentation Standards: Clinical documentation required in client records includes physical condition, presenting problems and relevant conditions, medications, mental health treatment history, use of alcohol, tobacco, and other drugs, mental status and five axis diagnosis. A complete developmental history is required for children and youth. Treatment plans must include specific observable or quantifiable goals, proposed type of intervention and estimated duration of intervention as well as documentation of the client's agreement with and participation in the plan. Regular progress notes must include appropriate signature and timely documentation of relevant aspects of client care, clinical decisions and interventions.

Child Health and Disability Program (CHDP) and California Children's Services (CCS). Both CHDP and CCS are administered by the Department of Health Services. Quality assurance standards for these two programs are explained on pages 43 and 44 of the state plan.

Section 8. Cost Sharing and Payment

Section 8.2.1

14. The plan provides a purchasing pool for premiums in which families selecting plans that are not designated as Family Value Packages (FVP's) will be responsible for paying the cost differential in addition to the baseline premiums. How will the State assure the premium fees for these plans will be within the Title XXI allowable limits?

The structure of Healthy Families has been designed to assure that subscribers have access to a wide variety of plans in the Family Value Package (FVP), with copayments and premium payments that are within the Title XXI limits, and to allow the subscribers to choose, and pay the cost differential for, other higher cost plans.

MRMIB's regulations guarantee that the FVP will be available to all enrollees. However, in recognition that many low income families will want to choose a lower priced plan and to ensure that there is wide access to the FVP plans, MRMIB recently made a change in the definition of the FVP plan that will significantly increase the number of plans that will qualify. Specifically, MRMIB increased the percentage of cost variance that forms the boundaries of the FVP from 5 to 10 percent, and included the average of two lowest priced combinations of health, dental and vision plans as the bottom-end pricing point.

This means that if the average price to the state for the two lowest cost combinations of health, dental and vision plans is $60, combinations of plans with rates up to 10 percent higher than $60 -- up to $66--would be available to subscribers for no additional premium. Designation of FVP's will be done on a county by county basis, thus assuring that regional pricing differences do not undermine the approach. Thus, subscribers will have a significant choice of plans with costs to the beneficiary under the federal limits. This also assures that there is adequate capacity among the FVP plans so that every subscriber will have access to the lowest priced plan. If MRMIB determines that the 10 percent range does not allow sufficient capacity in an area, it is authorized to extend the FVP range further.

One of the most important principles of purchasing pools generally, and the Healthy Families model in particular, is allowing people to have a bountiful selection of plans (and, therefore, providers) from which to choose and a fiscal incentive to encourage health plans to seek to be one of the lower cost plans.

The incentive that subscribers have to choose the lower cost plan is a prerequisite of the ability of a purchasing pool to contain overall costs of the program. This is because health plans will compete to be among the lower price plans so that they will be chosen. These principles underlie the creation of the Family Value Package concept in Healthy Families as well as the structure of the state employees purchasing pool run by Public Employees Retirement System (PERS) and the small employers purchasing pool (HIPC) run by MRMIB.

HCFA has indicated its concern that lower income families may not be able to pay for plans above the FVP limits -- and its view that this program feature is possibly discriminatory toward lower income families. We obviously see the issue quite differently. We believe that Congress' intent in including anti-discrimination language in Title XXI was to prevent states from offering different benefit packages to subscribers depending on their income, not to preclude choice. As you know, the State approach is modeled on the PERS health plan, which provides a fixed employer contribution toward the cost of health insurance. This fixed contribution currently covers the lowest priced plans available to state employers. State employees, including those earning under 150 percent of FPL, can choose a higher cost plan, but must pay the difference between the subsidy level and the cost. We think it is antithetical to the concepts of consumer choice and family responsibility to insist that persons of (lower) income levels not be offered the choice for a plan which costs a bit more, but contains features which they value and would like to purchase. If California is compelled to change the program design, we will have no choice but to exclude plans that are over the FVP limit. Eliminating choice in this regard is problematic and inconsistent with the policy objectives of consumer choice and plan competition.

As evidenced by the President's recent budget proposal, the Clinton Administration has advocated on behalf of pooled purchasing, in part because of its features related to choice and cost containment. Our approach to administering the Healthy Families Program balances the policy objectives of pooled purchasing with those of providing affordable health coverage to the uninsured. We are further aware that the basis of the approach taken by the President and Congress with regard to the State Children's Health Insurance Program was state experimentation with a number of different approaches to providing coverage to low income persons. We hope that HCFA will let California's approach proceed.

In response to HCFA's concerns regarding this matter, MRMIB is prepared to provide HCFA with yearly reports detailing the selection behavior of families. We will report on the number of families both above and below the 150

percent FPL who choose to enroll their children in a health, dental, and vision plan combination which exceeds the FVP price. Data will be presented by county, family size, ethnicity, and family language. The reporting will enable the State and HCFA to ascertain whether family choices are resulting in large numbers of the lower income families paying more than the $7-$9 per child per month FVP premium prices. If the State identifies concentrations of these families, we will contact the families to learn more about why they chose the higher priced plans and whether the costs above the FVP are a hardship on the family.

Section 8.2

15. Some copayments for individual services exceed the current limits that are allowable under Title XXI for families with incomes below 150 percent of FPL. Please clarify how the state will address this.

15.a. We are aware that the Secretary of the Department of Health and Human Services is presently reviewing policy options related to her authority to adjust Medicaid copayment amounts for inflation or any other reason the Secretary determines is reasonable. We note that if the Secretary did adjust the 1978 copayments for inflation, the copayments would equal $7 for families with incomes below 150 percent of FPL -- well above the $5 the Healthy Families plan requires for non-preventive services.

We urge the Secretary to adjust the copayments for inflation. By exercising her authority, the Secretary will enable Healthy Families to charge a copay that is consistent with cost-sharing requirements of similarly situated families insured through employer-based or privately purchased coverage. A key element in mitigating the incentive for families to drop employer based coverage in favor of Healthy Families coverage is assuring that Healthy Families coverage mirrors to the greatest degree possible employer-based coverage available in the general marketplace. Five dollar copays are the absolute lowest copays used in the California insurance market. Adopting a lower copay for Healthy Families could have the effect of exacerbating crowd out of private insurance coverage. Further, because Healthy Families utilizes health plans' commercial offerings, their operating systems are set up for $5 copays rather than $3 copays.

15.b. In the regulations which the Board adopted at its January 29 meeting, the Board reduced the copayments for both dental and vision care to $5 for non-preventive services (See Attachment A). The copays detailed in the State Plan were based on those charged to state employees under state dental and vision plans. They were higher than $5 particularly in the area of dental copays. The Board's review of the higher copay amounts indicated that the high copays were associated with services

rarely used by children. Thus copays for children's services were already between $0 - $5. The Board revised the regulations to clarify this matter in response to HCFA's opposition to higher copays for dental and vision services.

16. **The plan notes that the amount of copayments a family will pay in a given year is limited to $250. This limit however does not appear to be applicable for dental coverage. Please explain whether these copayments are applied to the $250 limit and whether these copays apply only to families above 150 percent of FPL. If the dental component functions outside of the health plan (i.e., the dental program may be a dental HMO contracting directly with the State and not part of the managed care organization providing the health care services), how will the state advise the two entities that the maximum cost sharing has been reached by the family so the patient is not charged additional copays beyond the amount permitted? How will MRMIB monitor that the $250 ceiling has been reached for all services? How will a family recoup monies should they accidentally be charged a copayment that puts them over the ceiling?**

The $250 limit does not apply to dental or vision coverage. This is because the provision of dental coverage under Title XXI is not required of states who opt to participate in the CHIP program. California, recognizing the value of these services and the importance of the dental health of our targeted low-income children, adopted the State employees' benefit package and copayments for dental and vision coverage. As these are optional benefits, and as the authorizing statute applies the $250 cap only to health benefits, our view is that the cap need apply only to health coverage.

Further, as California does not have copays for most dental services that children receive (preventive exams, cleanings, restorations, sealants, and fluoride treatments) it has lowered all other copays to five dollars. Children who meet CCS conditions will receive their services (orthodontics) from CCS without a copay. Therefore, including dental services in the $250 maximum is not needed. Very few families will have to pay a copay at all for dental services and those that do will be for a specific condition (root canal) which should have limited utilization. As shown by HCFA's questions, inclusion of dental in the maximum would be very complicated and the administrative cost and confusion to families could far outweigh any practical value of this inclusion.

Section 9. Strategic Objectives & Performance Goals for Plan Administration

Section 9.10

17. Additional information is needed in order to understand how the budget was constructed. Please provide details and the underlying assumptions used in developing the State's budget.

17.a. Attached are a series of exhibits which explain how the amounts proposed for benefits and other cost components were calculated. We note where the amounts proposed in the original plan have changed due to revised calculations or cost definitions and have shown these changes in a revised funding table (Exhibit 13).

Exhibit 1- Estimated enrollment and related costs for Healthy Family program benefits, premium payments, contractor payments and assistance fees.
Exhibit 2- Enrollment assumptions
Exhibit 3- Benefit cost assumptions
Exhibit 4- Average premium calculation
Exhibit 5- Basis for Title XXI-eligible Access for Infants and Mothers program costs (The AIM estimate has since been reduced by 4 percent in response to HCFA's concern that AIM covers infants with access to insurance coverage)
Exhibit 6- Basis for Title XXI-eligible California Children's Services program costs
Exhibit 7- Basis for Title XXI-eligible Child Health and Disability Prevention program costs
Exhibit 8- Basis for Title XXI-eligible Mental Health Services benefit and associated administrative costs
Exhibit 9- Assumptions and calculations for conforming Medi-Cal program costs for accelerated coverage, asset waiver, extended eligibility and outreach program costs (First year outreach costs revised to match chaptered legislation. First year estimate for extended eligibility has been reduced because California will have to pass state clean-up legislation before it can implement extended eligibility in accordance with HCFA's parameters. Original extended eligibility estimate assumed a May 1, 1998 implementation date, while amended estimate assumes a July 1, 1998 implementation date.)
Exhibit 10- Basis for cost estimate for the Fiscal Intermediary requirements (Revised cost estimate. California will claim Fiscal Intermediary costs under Title XIX rather than seek the enhanced FFP under Title XXI)
Exhibit 11- The state budget proposal for DHS administrative staff costs (Revised cost estimate includes amount for overhead costs consistent with the HCFA-approved indirect cost rate plan and additional application printing costs)
Exhibit 12- The state budget proposal for MRMIB administrative staff costs (Revised cost estimate includes additional financial accounting and processing staff in response to HCFA draft guidelines)
Exhibit 13- Revised State Plan budget table with revised administrative cost amounts and percentage calculations
Exhibit 14- Original State Plan budget table included for reference

17.b. In response to your concerns regarding defined benefit and administrative costs, we have made adjustments to our projected budget. First, we have shifted payments for the enrollment contractor and application assistance fees from benefits to administrative costs. Second, we have excluded fiscal intermediary system costs required for our Child Health and Disability Prevention (CHDP) program and the county costs to support our Medi-Cal conforming benefit changes from the enhanced FFP under Title XXI and will claim these costs instead under Title XIX. We have also reduced the costs associated with the statewide outreach campaign for which we propose enhanced FFP. These changes allow a revised state plan for California which complies with the 10 percent administrative cost limit for fiscal year 1999 and subsequent years. However, we request that HCFA provide an exemption for the first year's administrative costs.

18. Proposed administrative costs for FFY 1998 are significantly higher than the 10 percent limit established by the legislation for Title XXI. The method used by the State to determine its percentage of administrative costs to total program costs is not consistent with the instructions. Rather than dividing total program costs by a factor of 0.10 to determine the 10 percent limitation for administrative costs, the State combined both budgeted benefit and administrative costs and then divided administrative costs into the total to determine its administrative cost percentage. As a result, the current budget figures substantially understate the actual administrative cost percentage to benefit costs. Additionally, two of the line items included in the budget as benefit costs appear to be administrative costs. These two items are (I) payments to enrollment contractors and (II) payments for application assistance fees. If these two items are, in fact, administrative costs, the 10 percent administrative cost limit would be exceeded in each of the three program years.

We have several issues with the statements about administrative costs in this item.

First, it is true that administrative costs exceed the 10 percent limit for the first federal fiscal year of the program. As stated in our State Plan (page 63-Start Up Costs), we do not believe it is reasonable to hold administrative costs below 10 percent of expenditures until a sizable number of children have been enrolled, clearly an issue in the first year. Further, the imperative to invest in the vital administrative activities of outreach and education, consistent with President Clinton's direction to HCFA and the States, is at odds with the 10 percent limit in year one. California is prepared to "go the extra mile" to identify and enroll eligible children, but we hope that the Federal government will recognize the resources required for this effort.

We also disagree with the statement that the second and third year administrative costs have been calculated incorrectly. We believe our calculation of the percentage of administrative costs is correct. The calculation we used, dividing total administrative costs by total program costs, yields a percentage result which is consistent with, and comparable to, the 10 percent administrative cost limit calculated by either of two methods, the method described in Item 18 of your letter (10 percent limit = total program costs/10) or the method cited in the December 8, 1997 HCFA letter containing draft fiscal provisions (10 percent limit = total benefit costs/9). Using the amounts proposed for FFY 1999 in the table on page 64 of our State Plan, total program costs of $261 million divided by 10, yields an administrative cost limit of $26.1 million or 10 percent, and higher than our proposed administrative cost total of $24.7 million, or 9.4 percent of total program costs. Using the second method, dividing total benefit costs of $237 million by 9 yields a cost limit of $26.3 million, also higher than the proposed $24.7 million.

Finally, after discussions with HCFA staff, we have revised the state plan funding table to reflect two items as administrative rather than benefit costs, the application assistance fees and administrative vendor payments.

19. Clarification is also needed on how the State will be allocating administrative costs between Title XXI and Title XIX activities. In addition, further detail is requested on how MRMIB will allocate operating costs between its Title XXI activities and those of its three existing programs.

MRMIB will implement a uniform system for determining costs in accordance with Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." To ensure the proper determination of allowable costs, all costs charged to Title XXI will be reviewed to ensure that they are necessary, reasonable, adequately documented, and properly reconciled. Additionally, MRMIB will establish a periodic review of our cost structure to ensure that operating costs are properly allocated among the appropriate federal and state programs.

For example, personal service costs, i.e., salaries and wages and employee benefits, will be properly documented and certified to ensure proper allocation to Title XXI. Specifically, MRMIB is implementing a time reporting system that uses detailed activity reports and monthly certifications to document and account for the total activity of each employee and for time charged to Title XXI and/or the three existing state programs.

Indirect costs will be determined according to cost objectives and program goals. Using OMB A-87 guidelines, its supplements, and checklists, we will develop a

comprehensive cost allocation system that clearly defines the nature of the costs, i.e., direct or indirect.

Currently, the operating costs of MRMIB's three existing state programs are separately tracked and reported in the state accounting system. All administrative contracts are assigned separate control numbers for proper tracking and reporting of financial activities related to their respective programs.

DHS has in place a program cost accounting system, CALSTARS, which tracks and allocates direct and indirect costs in accordance with Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." This system uses a clearly defined set of program cost account codes, object (type of cost) codes and fund source codes to support the accurate allocation of benefit costs, as well as administrative and overhead costs, among all programs, including Title XIX and other federal and state fund sources. The system will support Title XXI accounting as well. A key component of this system is the Indirect Cost Rate Plan (ICRP) which is reviewed and approved by HCFA. The ICRP process applies a predetermined, approved-budget-based, percentage rate to direct salary and benefit costs in order to allocate departmental and statewide overhead (executive and administrative support) uniformly to all direct programs and fund sources.